Improving Care for Dual Eligibles through Health IT

The National Dual Eligibles Summit
Duals Market is sizable

Medicare and Medicaid Populations

- Total Enrollment (Millions)
  - **Medicaid**
    - Total ABD = 15M
    - Dual = 9 M
    - Non-Dual: ABD = 6 M
    - Medicare SNP = 1.5 M
    - Total Medicaid = 63M

- **Medicare**
  - Non-Dual Medicare = 39 M
  - Total Medicare = 48M

Payments ($ Billion)

- **Medicaid**
  - Total ABD = $257B
  - Medicaid Duals = $152B
  - Non-Dual ABD = $105B
  - Total Medicaid = $389B

- **Medicare**
  - Duals = $298B
  - Medicare Duals = $146B
  - Non-Dual Medicare = $326B
  - Total Medicare = $472B

- Small number of people (~9M) drive large spend and usage (~$300bn)
- MCO market for Duals will grow significantly – we estimate an addressable market of $90B–$184B in the next five years

Source: Kaiser Family Foundation based on Medicare and Medicaid 2008 and 2009 data, Booz & Company analysis
State level variations matter

Opportunities for Managed Care Organizations through CMS Duals Programs
States Coded by Approach Category and Market Sizing

- >200K duals, MCO only
- 100-200K duals, MCO only
- <100K duals, MCO only
- >200K duals, MCO or other managed care
- 100-200K duals, MCO or other managed care
- <100K duals, MCO or other managed care
- FFS/ACO only or not participating in CMS integrated care programs
Duals Population is unique to manage

- 4% of all Medicaid constitute 48% of spend – most are Duals
- 15% of Medicaid and 39% of spend; 18% of Medicare and 31% of spend
- Duals have higher levels of chronic illness (Institutionalization at 10x and Limited ADL at 2x), are poorer (poverty rates 6x), and less educated (fraction w/o high-school diploma is 2.5x)
- The highest cost – aged with dementia or disabled with 2 or more impairments – cost more than double the average
- Not all Duals are high-utilizers. Bottom 50% is only 10% of spend and 40% of them had less than $7K combined

Source: MEDPAC June 2011 Report, analyst reports, Kaiser Foundation Profiles of Medicaid’s High Cost Populations; March 2012 Report to Congress on Medicaid and CHIP; Health Affairs “Among Dual Eligibles, Identifying The Highest- Cost Individuals Could Help In Crafting More Targeted And Effective Responses” 2012
What are their specific needs?

- Integrated benefit, and one ID card
- Easy to understand coverage and help navigating the health system
- Integration of care – between physical and behavioral aspects; institutional, home health care, community and long term care settings; and multiple care touch points
- Coordination with other care collaborators – including social organizations, community groups, providers of transportation / meal services etc.
- Much higher degree of hand-holding, direct engagement, and assistance in daily living
- Implied \(\rightarrow\) higher bar for information sharing, and aligning incentives between different programs and participants
Traditional approaches fall short

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<tr>
<th>Traditional Care Management Approaches</th>
<th>Challenges</th>
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<td>Ad Hoc Communications</td>
<td>Lack of care coordination leads to redundancy and no / low utilization of low cost care venues (e.g., clinic vs. ED)</td>
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<td>Patient</td>
<td>Lack of integration between behavioral and physical for patients with mental disorders</td>
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<td>Provider Systems</td>
<td>Intent to limit access to care through utilization management causes concern from public policy and misaligns goals</td>
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<td>Long Term Care Facilities</td>
<td>Disease or case management nurses do not integrate care adequately with providers creating gaps and confusion</td>
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<td>Pharmacy</td>
<td>Limited engagement of family members and community groups for support</td>
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<td>Behavioral Health</td>
<td>Communication through telephonic outreach is of limited success: many beneficiaries don’t have phone access and numbers change frequently</td>
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<td>Dieticians Fitness</td>
<td>Traditional web tools for education and monitoring of patients might be less effective due to connectivity and technology usage issues</td>
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<td>Primary Care</td>
<td>Lack of integration and coordination between institutional and long term care facilities or other settings where they reside</td>
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Booz & Company
New holistic model with 5 key attributes

**Key Differences from Traditional Approaches**

**A Integrated Care Coordination**
- Care coordination across continuum specialists, hospitals, long term care
- Integrated with behavioral health specialists and substance abuse organizations

**B Engagement and Outreach**
- Incentives to engage members in health
- Multiple in person touch points by care team, with phone calls to subset of them

**C Care Collaborator Relationships**
- State agencies, social services and other community groups to support care plan

**D Incentives**
- Alignment of incentives to ensure “active” management of cases
- Development of new incentives for members and other care collaborators

**E Informatics**
- Stratification of high utilizers, ability to predict future high risk members and tracking related care interventions
Complex set of capabilities will be needed

Capability Building Blocks for New Integrated Duals Models

Integrated Service Delivery Model

= 

State-Specific Medicaid Capabilities

General Medicare Capabilities

+ 

New Integrated Program Requirements for Participating Health Plans

State A Medicaid Requirements

State B Medicaid Requirements

State C Medicaid Requirements

Medicare Program Requirements for Health Plans

New Duals Integrated Program Capabilities
Innovation & technology will play a key role

- Digital social media
- Accessibility of care information across multiple channels

- Digital geo-demographic analytics
- Clinical and claims analytical tools
- Predictive disease and case management tools

- Digital wellness platforms
- Social media and local engagement groups
- Mobile applications

- Patient monitoring and connectivity tools
- Digital wellness platforms
- Mobile diagnosis and monitoring tools
- Peer to peer networks and provider connectivity solutions
- Shared information networks

- Provider information sharing and collaborative networks
- Mobile health lifestyle rewards
For payors, scalable IT capabilities to integrate data, claims and analytics critical

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<th>Required Capabilities</th>
<th>Description</th>
<th>Implications for Payors</th>
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| Integrated Care Management             | ▪ Platform used to present a whole member view across payor care management interventions  
                                          ▪ Ability to integrate care management IT tools/ analytics across care continuum | ▪ Platform interoperability is a key concern for health plans                           |
| Integrated Claims Processing           | ▪ Duals integration demos require combining financing from both Medicaid and Medicare  
                                          ▪ Benefit carve-outs require claims systems be adaptable to public vs. private health plan reimbursement, e.g., Rx carve-outs | ▪ Claims processing systems must be adaptable to integrate multiple funding and billing systems  
                                          ▪ Legacy billing systems may need to be updated/ replaced for new models               |
| Integrated Informatics                 | ▪ Ability to show members utilization across Medicare and Medicaid benefits  
                                          ▪ Advanced analytic capabilities necessary to meet needs and adequately manage high-needs, high-utilizing population, e.g., ability to risk-stratify population to target highest utilizers | ▪ Invest in advanced analytics capabilities through strong vendor or in-house  
                                          ▪ Adapt current systems to leverage that data for advanced analytics                   |
As such, many plans investing in IT capabilities for Duals

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<th>Health Plan</th>
<th>Description</th>
<th>Duals-Relevant Capabilities</th>
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<td>Analytics Play</td>
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<td>• UnitedHealth has developed Optum Insight, formerly known as Ingenix, into a health IT company within its Optum portfolio</td>
<td>• <strong>Risk assessment</strong> capabilities to analyze population health indicators</td>
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<td>• Optum Insight offers a wide array of analytics services to health plans, government, providers and life sciences companies</td>
<td>• <strong>Cross-care continuum tools</strong> that allow for broad integration of analytics and platforms</td>
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<td>Humana</td>
<td>• Humana acquired Anvita in 2011</td>
<td>• <strong>Custom based rules</strong> functionality that allows for specific members and providers to be targeted with alerts and other messaging</td>
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<td>• Anvita offers “real-time analysis” of member information with targeted “behavior-based messaging” both to members and providers</td>
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<td>Aetna</td>
<td>• Aetna acquired ActiveHealth in 2005</td>
<td>• Products for <strong>advanced care management, care coordination and population health management</strong> that help plans/providers target and care for select populations</td>
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<td>• ActiveHealth serves payor, plan sponsor and provider clients, as well as consumers directly with clinical decision support and health and wellness solutions</td>
<td>• <strong>Consumer-facing solutions</strong> (e.g., through partnership with subsidiary iTriage) to aid members directly</td>
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Key Takeaways: Duals Segment

- **Market opportunity** is sizable but one size does NOT fit all – state-level variations are important

- **Population** characteristics are unique – it’s as much about where you do not focus as about where you do

- **Care Coordination** Care and Medical Management required to be successful is more like “Holistic” Life Management and Individualized

- **Capabilities and platforms** will need to integrate local state-level Medicaid competencies, Medicare requirements, and new dual program requirements

- **Innovation & technology** will play a key role in addressing the unique needs of this population
Thank you! Q&A...

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